Women's Physician Surgery Center

Pt. Sticker

Patient Medical Record

What Type of Procedure are you having done today?____________________________

Patient's Age:________ Height:______ Weight:______

Allergies (medication, oral pain pills, iodine, latex, tape, etc.)	**Type of Allergic Reaction**

Current Medications: (include herbals/vitamins, prescribed and over-the-counter, taken regularly or as needed in the past month)

Specific Name of Drug	**Amount/How Often**	**Reason for Taking**	**Last Time Taken**

(Anesthesia Problems: nausea, vomiting, prolonged paralysis, problems waking up, malignant hyperthermia, high fever, breathing problems, Pseudocholinesterase deficiency, intubation trouble)

Have you ever had problems with Anesthesia? No Yes, Explain____________________

Has anyone in your family had problems with Anesthesia? No Yes, Explain____________________

Last normal menstrual period:__________ Possibility of patient pregnancy?: No Yes N/A

Previous Surgeries/Procedures (please be specific):____________________________

____

Medical History (if Yes, circle appropriate illness)

Y N

☐ ☐ Cardiac Problems/Heart Murmur/Mitral valve prolapes

☐ ☐ Hypertension/Chest Pain

☐ ☐ Asthma/Emphysema/shortness of breath/sleep apnea

☐ ☐ Recent Cold or Flu/Chronic Cough/Fever

☐ ☐ Hearing/Speech/Vision Problems

☐ ☐ Do you have contact lens in?

☐ ☐ Numbness/Weakness to Extremities

☐ ☐ Skeletal structure injury/Disabilities/Back Problems

☐ ☐ Seizures/Epilepsy

☐ ☐ Depression/Anxiety/Memory Loss

☐ ☐ Migraines

☐ ☐ Diabetes

☐ ☐ Cancer____________________

☐ ☐ Thyroid Problems

☐ ☐ Digestive/Bowel Problems/GERD or reflux

Y N

☐ ☐ Kidney disorder or Bladder Problems

☐ ☐ Hepatitis

☐ ☐ TB, HIV or infectious disease

☐ ☐ Circulatory/Clotting Problems (Deep Vein, Thrombosis, Pulmonary Embolism, Factor V Leiden's)

☐ ☐ OB/GYN Problems

☐ ☐ Implants/Pins/Prosthetic Joints

☐ ☐ Loose/Chipped/Capped/False Teeth/Dentures

☐ ☐ Alcohol Use_/drinks per day

☐ ☐ Drug Use__________

☐ ☐ Smoker__________/packs per day/____years

☐ ☐ Liver or Gall Bladder Problems

☐ ☐ Bleeding Tendencies or Problems (Hemophilia, Von Willebrand's, Factor 8 deficiencies)

☐ ☐ Ω Other

Additional Comments:____

____

Name of Person Driving Patient Home: ________________ Relationship to Patient: ________________

Phone # (if needed)______________________

Patient Signature: ______________________________ Date: ______________

Reviewed by:_________________________/_________________________ ____________

(Anesthesiologist Signature) (Nurse Signature) (Date)